Social Drivers of Health: an overview and update

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Agenda

1. Key Definitions
2. Importance
3. Screening
4. What's next?

Social Drivers of Health

Key Definitions

*“**The conditions in the environments where people are born, live, learn, work, play, worship, and age** that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors.”*

Social Drivers of Health and Health-Related Social Needs | CMS

Definitions: SDOH

CDC Definition

- non-medical factors affecting health, like socioeconomic status, and geographic location

WHO Definition

- non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.
- These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Social Determinants of Health | Public Health Gateway | CDC

Social determinants of health (WHO)

Health Equity

The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes

Health Disparities

Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations

Underserved Community

Individuals who share a particular characteristic – demographic, geographic (urban or rural), or other factor – that results in them being systemically denied full opportunity to participate in aspects of economic, social, and civic life

Safety Net Providers

Providers that organize and deliver health care to uninsured, Medicaid, and other underserved patients. Safety net institutions include Community Health Centers (which include Federally Qualified Health Centers (FQHCs)) and their look-alikes, Rural Health Clinics, and public and critical access hospitals.

SDOH Contributors impactors to public health

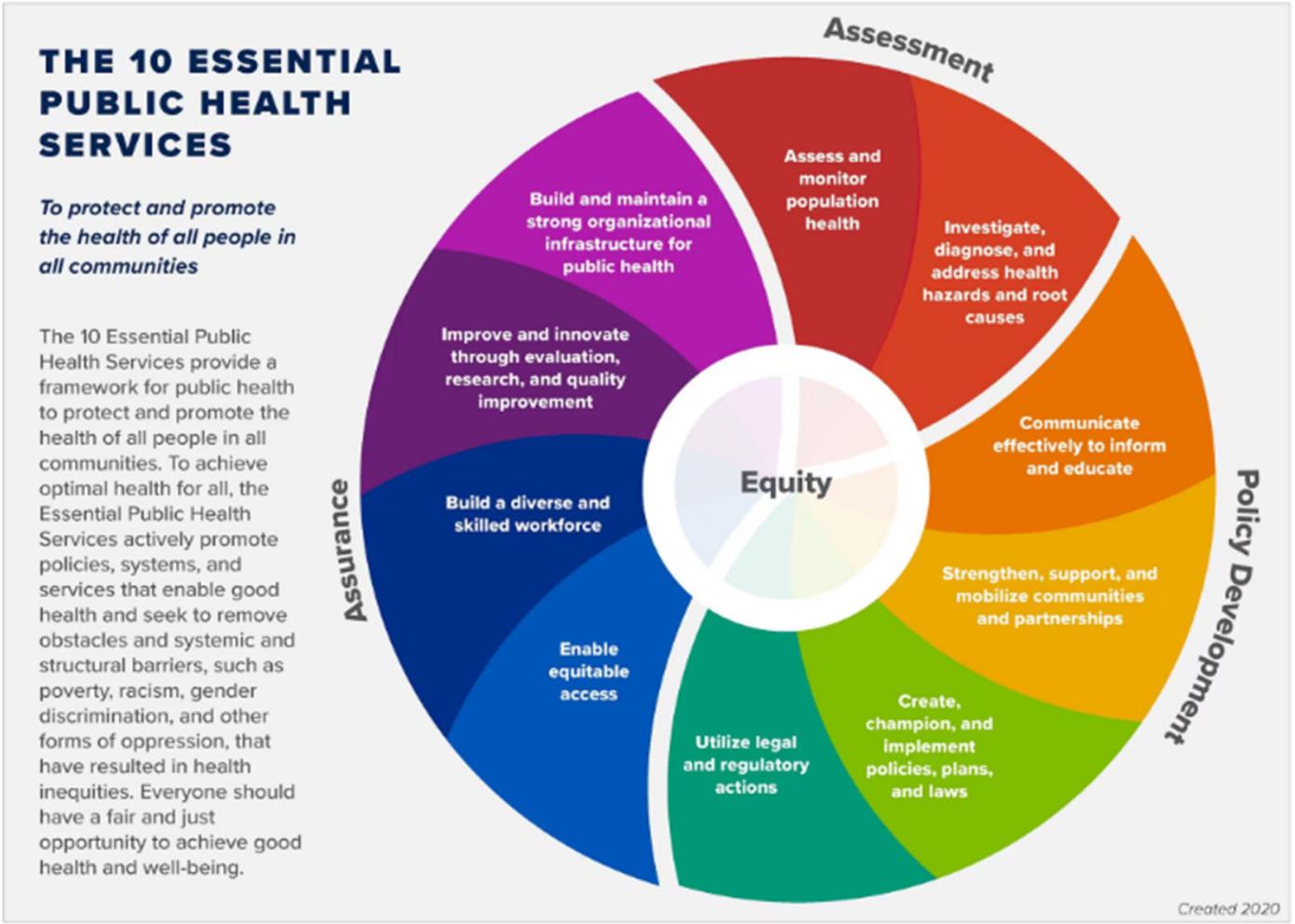
- Poverty
- Discrimination
- Poor access to:
  - Quality jobs
  - Education
  - Housing
  - Safe environments
  - Healthcare

Social Determinants of Health | Public Health Gateway | CDC

10 Essential Public Health Services | Public Health Gateway | CDC

The CDC 10 Essential Public Health Services

- describes the public health activities that all communities should undertake
- framework for carrying out the mission of public health
- First released in 1994, updated in 2020



What makes us? What makes our health?

- Socioeconomic factors
- Health behaviors
- Health and medical care services
- Natural environment

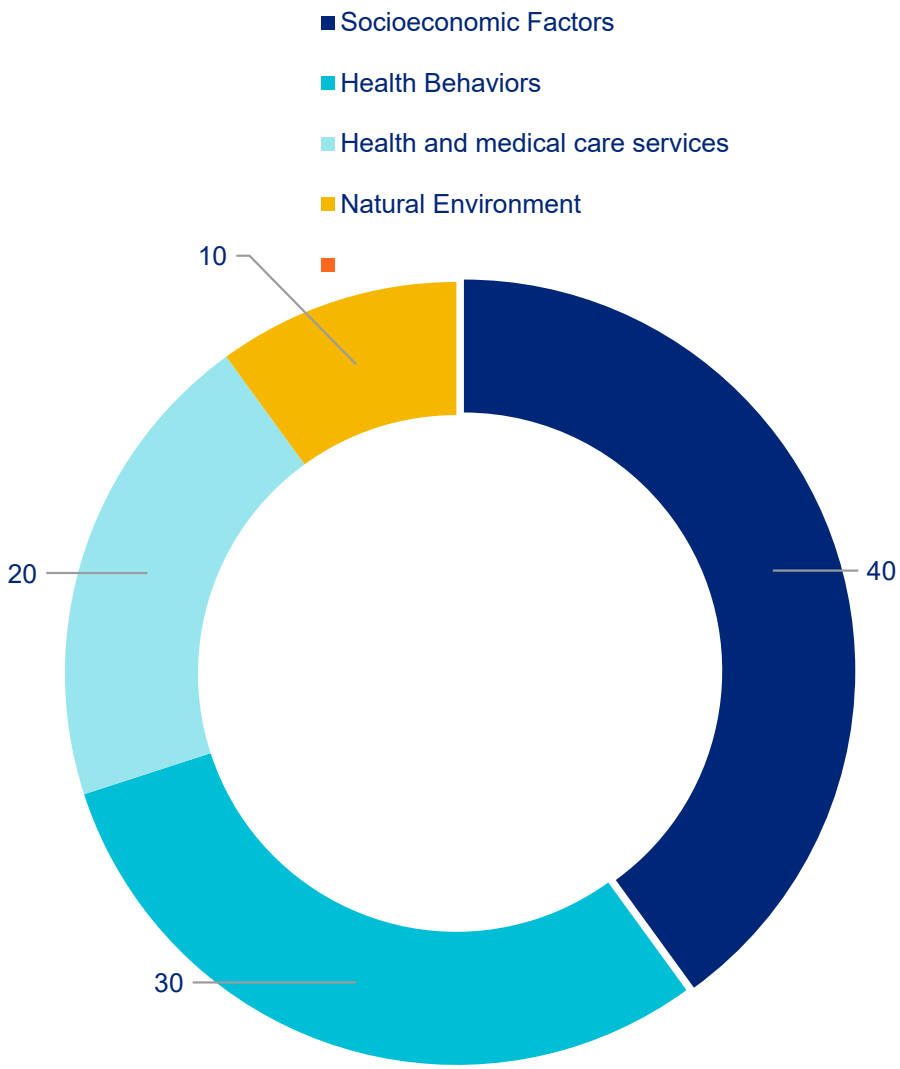
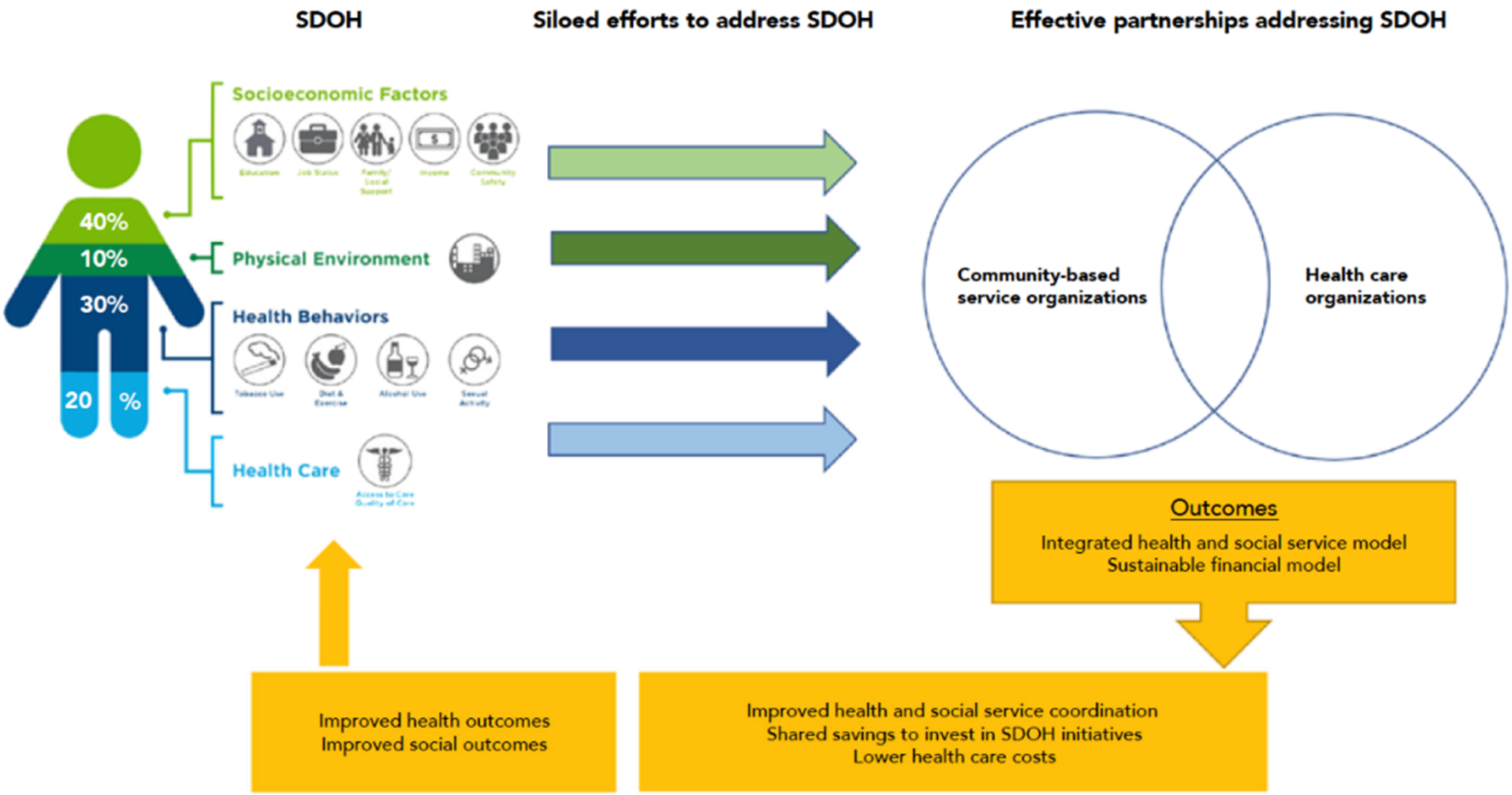


FIGURE. Addressing the SDOH[10,11]



1. Image from the Stanfard Social Innovation Review (now closed)
2. Understanding the Financial Return to Investments in the Social Determinants of Health
Scanlon DP and Sciegaj M. Population Health, Equity & Outcomes. Volume**30** Issue **Spec No. 13**Pages: e2-e7. October 2024

Importance

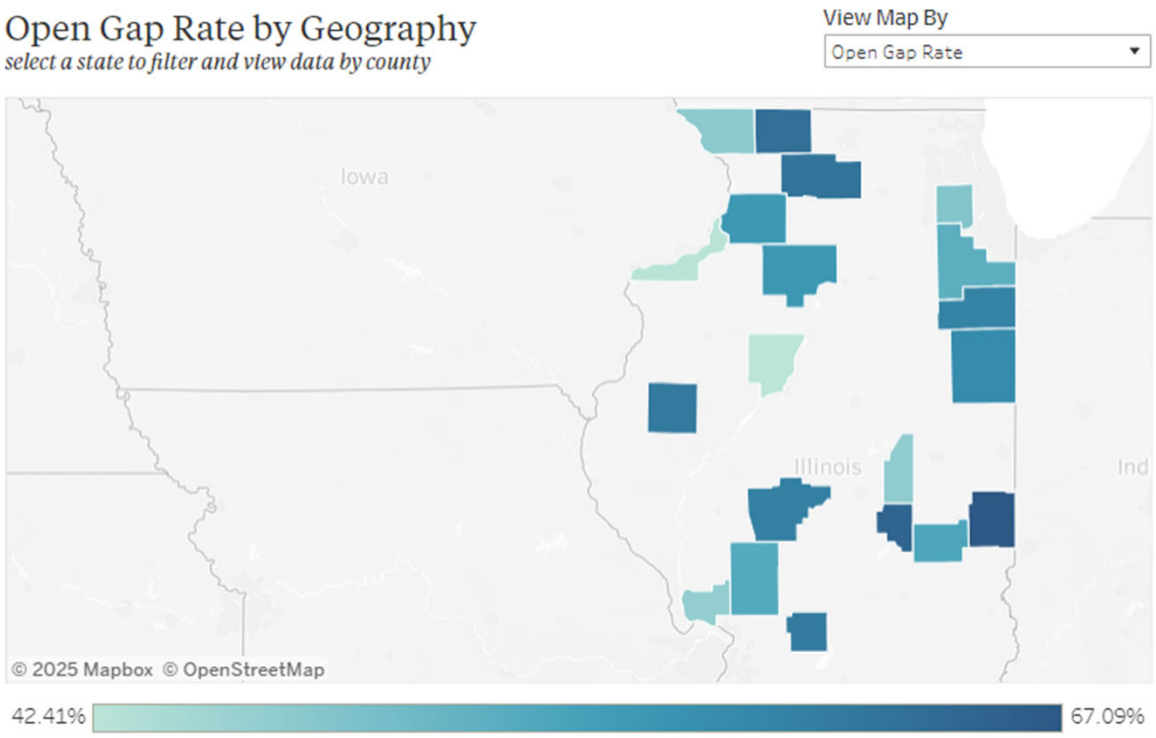
Why it's important

- Based on education alone, if disadvantaged or less educated Americans could improve their health and longevity to that of college educated Americans, the economic value accrued would amount to $1.02 trillion.
  - ***This was based off of 2011 data….***
- In the context of the work we do, putting a lens on health equity should include ensuring our members have access to support, resources and treatment to support their success

The Economic Value of Improving the Health of Disadvantaged Americans
Schoeni, Robert F. et al.
American Journal of Preventive Medicine, Volume 40, Issue 1, S67 - S72

My Community as an example

- The percentage of open gap opportunities for CRC screening is 6% higher in Cook County compared to 2 neighboring counties



198,592
Eligible Members

101,938
Open Gap Opportunities

51.3%
Open Gap Rate

Geography	Eligible Members	Open Gap Opportunities	Open Gap Rate
Cook	61,757	33,471	54.2%
DuPage	20,093	9,715	48.4%
Lake	16,409	7,745	47.2%
Will	13,724	7,199	52.5%
Kane	9,155	4,582	50.0%
Madison	9,842	4,330	44.0%
McHenry	7,152	3,795	53.1%
St. Clair	7,157	3,345	46.7%
Peoria	5,232	2,219	42.4%
Rock Island	4,533	1,932	42.6%
Tazewell	4,004	1,752	43.8%
Kendall	2,702	1,413	52.3%
Winnebago	2,227	1,365	61.3%
Sangamon	1,790	1,081	60.4%
Kankakee	1,692	1,011	59.8%
LaSalle	1,461	979	67.0%
Henry	1,768	730	41.3%
Knox	1,270	726	57.2%

The Adobe Study

- Adobe reviewed two years of Medicare member data across a state-wide catchment area in the Southwestern U.S.
- The sample: targeted interventions impacting 2,355 individuals.
- The analysis reviews a year of claims data without SDoH intervention and another full year following when the SDoH risk was addressed. They looked to determine if a significant impact could be identified in:
  - General demographics
  - Total inpatient visits
  - Total cost of care (based on claims cost)
  - Care gap closures around common but significant chronic conditions
- Overall, the study found that the annual average healthcare cost reduction per member dropped from $13,500 to just under $9,500. Providing a 31% reduction in average healthcare costs.

The Impact To Total Cost of Care

- A member with an SDOH Risk has:
  - 28% higher in patient admission rates/1000
  - Nearly 2X ER admission/1000
  - A PMPM of $1260 vs $1140 for those with no risk

Screening for SDOH

CMS and Screening Requirements & Recommendations

- Inpatient Prospective Payment System (IPPS) 2024:
  - Introduced the inclusion of homelessness (sheltered and unsheltered) as a complication or comorbidity (CC) for inpatient reimbursement under the Medicare Severity Diagnosis Related Groups (MS-DRG) payment system.
- CMS has proposed expanding its SDoH initiatives to outpatient settings in its 2025 Outpatient Prospective Payment System (OPPS) Proposed Rule.
  - This proposed expansion will occur in stages, starting with voluntary reporting in 2025, followed by mandatory reporting in 2026.
  - The goal is to screen patients for five key health-related social needs (HRSNs): food insecurity, housing instability, transportation challenges, utility difficulties and interpersonal safety

Examples of Available Screening Tools

SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH

Three screening tools can aid physicians in addressing multiple social determinants of health in a primary care setting.

Screening tool	Number of questions	Source
The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	15 core, 5 supplemental	http://www.nachc.org/research-and-data/prapare/toolkit/
The American Academy of Family Physicians Social Needs Screening Tool	11 (short form) 15 (long form)	Short: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf Long: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf
The Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool	10 core, 13 supplemental	https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

The AHC-HRSN tool draws on evidence from several need-specific assessments, below, which can provide valuable background.

A Practical Approach to Screening for Social Determinants of Health | AAFP

Screening Tools

The AHC-HRSN tool draws on evidence from several need-specific assessments, below, which can provide valuable background.

Social determinant	Assessment	Validated population	Background
Food insecurity	Hunger Vital Sign	Low-income families with young children	http://childrenshealthwatch.org/public-policy/hunger-vital-sign/
	U.S. Department of Agriculture U.S. Household Food Security Survey	Households with reported annual incomes below 185 percent of the federal poverty level	https://ssrn.com/abstract=2504067
Housing instability	District of Columbia Department of Health & Human Services Temporary Assistance for Needy Families Comprehensive Assessment - Housing Domain	Families at risk of or experiencing homelessness	https://www.acf.hhs.gov/sites/default/files/ofa/enhancing_family_stability.pdf
	National Center on Homelessness Among Veterans Homelessness Screening Clinical Reminder	Veteran population	https://www.va.gov/homeless/nchav/research/assessment-tools/hscr.asp
Interpersonal safety	Hurt, Insulted, Threatened With Harm and Screamed Domestic Violence Screening Tool	Men and women	https://www.baylorhealth.com/PhysiciansLocations/Dallas/SpecialtiesServices/EmergencyCare/Documents/BUMCD-262_2010_HITS%20survey.pdf
	Women Abuse Screening Tool – Short Form	Women	http://www.fpnotebook.com/prevent/Exam/WstScrnFrIntmtPrtnrVlnc.htm
	Partner Violence Screen	Women	http://www.fpnotebook.com/Prevent/Exam/PrtnrVlncScrn.htm
	Abuse Assessment Screen	Women	https://www.acog.org/About-ACOG/ACOG-Departments/Women-with-Disabilities/Abuse-Assessment-Screen
Utility needs	Children's Sentinel Nutrition Assessment Program	Families with children younger than 3 years old	http://pediatrics.aappublications.org/content/pediatrics/122/4/e867.full.pdf

A Practical Approach to Screening for Social Determinants of Health | AAFP

Sample questions: Housing

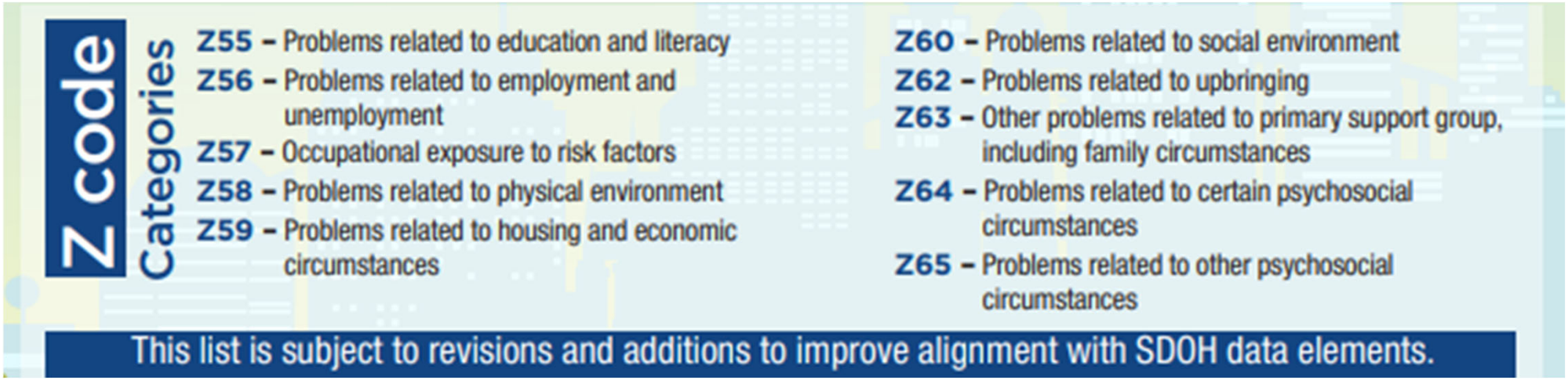
- **Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?**
  - Yes
  - No
- **Think about the place you live. Do you have problems with any of the following? (check all that apply)**
  - Bug infestation
  - Mold
  - Lead paint or pipes
  - Inadequate heat
  - Oven or stove not working No or not working smoke detectors Water leaks None of the above food
- **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**
  - Yes
  - No
  - Already shut off

Other Sample Questions

- Within the past 12 months, you worried that your food would run out before you got money to buy more.
  - Often true
  - Sometimes true
  - Never true
- Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
  - Often true
  - Sometimes true
  - Never true
- Do you put off or neglect going to the doctor because of distance or transportation?
  - Yes
  - No

CPT Z – Codes: Here to save the day?

- Z-Codes may be the way for payors, providers and beyond to trend SDOH data and what ultimately to do about it



USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM diagnosis codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] https://www.cms.gov/medicare/icd-10/2024-icd-10-cm

[2] https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Furthering Screening

- **A study reveals** physicians "are increasingly asking their patients about their needs for food and housing during medical appointments, but the frequency of such screening remains low"
- 27% of physician practices studied screened for five common social risk factors in 2022 (up from 15%)
- Only "three-quarters of practices responding to the 2022 survey screened for at least one social risk, up from 67% in 2017."
- Interpersonal violence was most often screened.
- **Between the lines:** Screening for social needs was more likely to occur at federally qualified health centers.
  - Health care facilities "that had a culture of innovation, advanced information systems and more exposure to alternative payment initiatives from insurers also screened patients at a higher rate."

Screening to Action: Community Health Workers

1

Navigators

Better understanding between community members and the health and social service system.

2

Engagement

Improved adherence to health recommendations.

3

Advocacy

Increased health and screening and use of healthcare services.

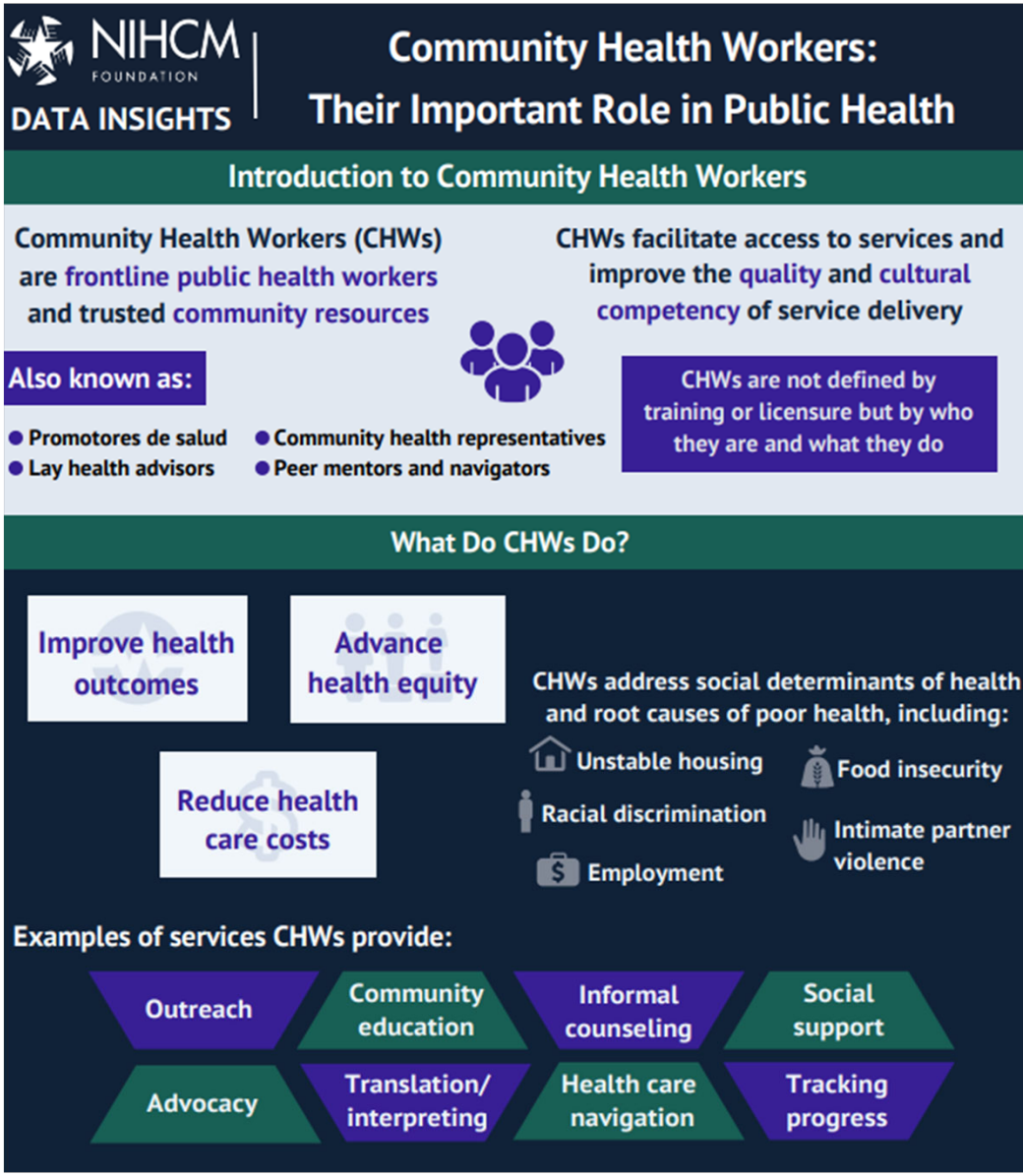
4

Cultural competence and community expertise

Advance health equity

Community and Cultural Public Health Improvement

Community health workers (CHWs) are frontline public health workers who bridge the gap between historically marginalized communities, healthcare, and social services.

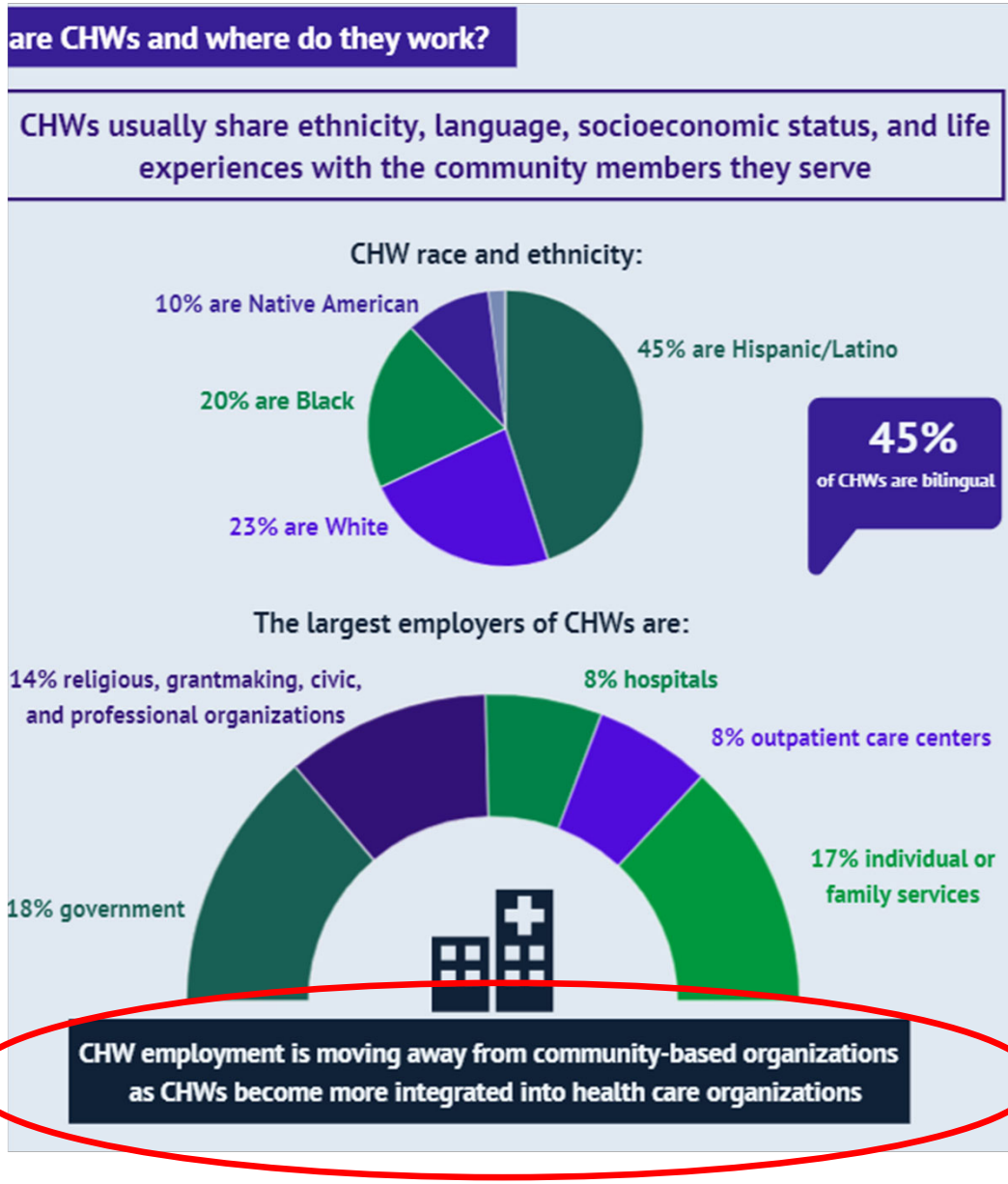


A Review of Community Health Worker Integration in Health Departments - PubMed (nih.gov)

Community Health Workers: Their Important Role in Public Health (nihcm.org)

Competent Care

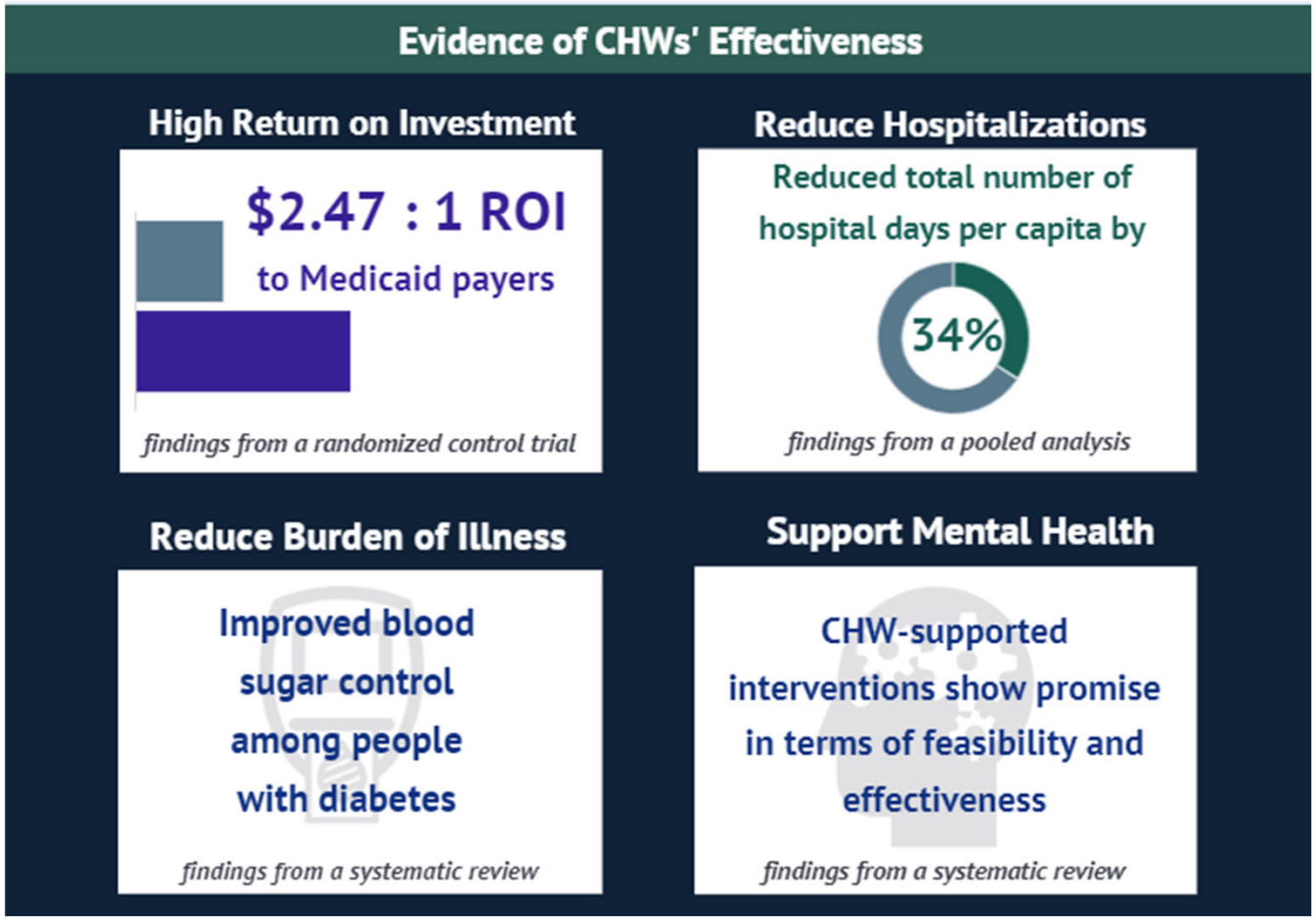
- In the Chicago area, culturally competent care is imperative.
  - -30% black
  - -30% Hispanic ethnic background
  - -Patients who shared the same racial or ethnic background as their physician were more likely to give the maximum patient rating score.



Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings | Health Policy | JAMA Network Open | JAMA Network

The benefit

- Community Health Workers: Their Important Role in Public Health (nihcm.org)
- Personal navigation support
- Another way to promote engagement with a personal touch
- Knows the community (vs a remote advocate who may not know the market)



How we are involved

Optum/UHC Initiatives

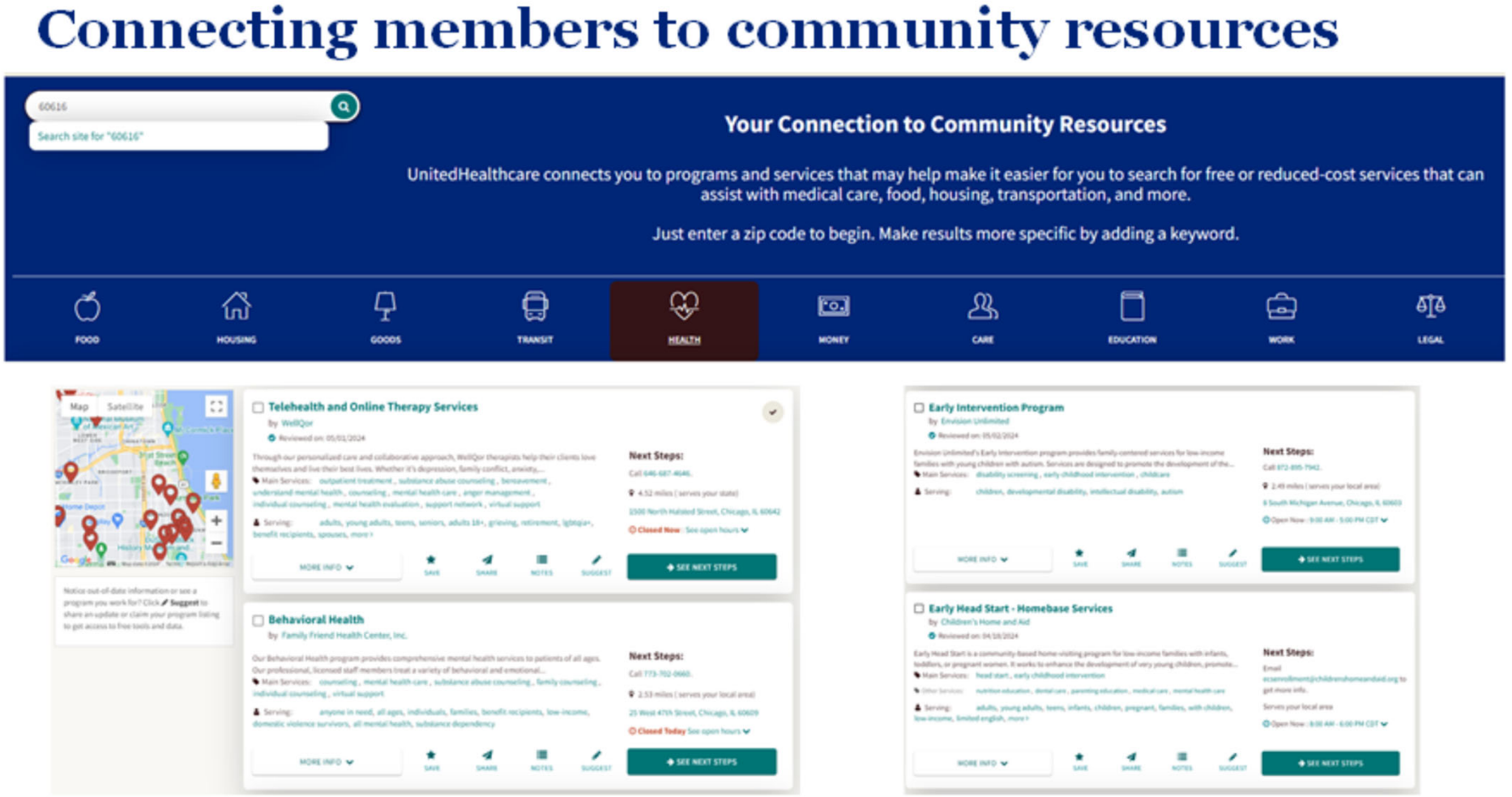
- Commercial is in phase 1 of SDOH SNS-E (*electronic social need screening and intervention*), DSF-E (*electronic depression screening*), Prenatal/postpartum depression screening).
- EPIC EPP is a largest source of data, but providers need to utilize the SDOH module for us to ingest this data.
- Because data is limited and new, no interventions/opportunities have yet been developed.
- We do have an SDOH database through Optum for all LOB's/Enterprise, SDOH Data Warehouse.

Where we can help

- Collaborating with institutions
- Data Analytics
- Interactive tools
- Programs
- Housing support
- Employer Education

Ours to share…

Healthier Lives by findhelp - Search and Connect to Social Care



Thank you!

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